CIH Transform Webinar
Providers
December 3, 2015, 10:00 AM
December 17, 2015, 10:00 AM

*The following questions and answers are from the December 3 and 17, 2015 CIH Transform Webinar. Based on feedback during public comment, modifications to the draft application have been made, therefore, please note that questions that are no longer relevant to the CIH waiver application have not been included in this document. In addition, if additional information has become available or an answer changed since the Webinar, you will find an *asterisk by the answer with the corrected information for the waiver application as submitted. Questions are categorized by topic for convenience of the reader, with duplicates or similar questions removed. Questions regarding this document or the CIH waiver application may be submitted to CIHW@fssa.in.gov*

Implementation:

When will changes go into effect?
Pending CMS approval, DDRS intends to implement changes October 2016.

Isn't a requirement to post all public comments when it regards policy changes?
DDRS will post the public comments to the CIH application. While we will share and respond to all comments, you may notice that we respond to some comments simply with "thank you for your comment." This response is used when the writer submits a comment rather than a question. DDRS has also made available summary from the town hall sessions and the webinars.*

What is the time frame if CMS approval is given?
DDRS has asked for an effective date of October 1, 2016.

Services:

What changes will be made to Wellness Coordination?
The service definition for Wellness Coordination has not changed.

Providers have expressed at multiple provider meetings the need for changes to the wellness coordination service definitions and reimbursement rate. Will the rate be re-examined? Will the focus on paperwork be shifted to a more client-centered approach?
The rate for wellness has not been adjusted in this proposed amendment.

Does the new Wellness component require a RN?
Wellness coordination does require a RN to oversee the services.

Are the current wellness criteria for each Tier being re-visited regarding the number of consult/reviews and face to face required?
DDRS has received differing feedback from providers. We did not feel that we had enough information at this time to make changes since Wellness Coordination is still a new service.

Please clarify what nursing services will be required for 24/7 supports in the CIH waiver.
All waiver participants have supports through the state plan. Wellness Coordination will still be a standalone service for individuals who qualify for that service.

Will the documentation standards for Wellness Coordination remain the same?
DDRS did not propose changes to the Wellness Coordination service definition in this amendment.

Are there caps on the transportation services? Are they the same as the current caps? Do both transportation options count towards the same cap?
The caps will remain the same under proposed changes. Individuals will have more transportation dollars available to them than they do today if they receive both Non-Medical Transportation and Employment Transportation.

For non-medical transportation, does habilitation training include pre-vocational and facility based services?
Yes, habilitation training includes pre-vocational and facility-based services.

For Employment related transportation, will the $2500 rate be a flat yearly rate or will it be broken down into units/months?
Under the waiver amendment, DDRS has not proposed a change to the method of authorization.

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Under the waiver amendment, DDRS has not changed the method of authorization.

Several of the definitions state that concurrent provision of two authorized services for the exact time period cannot be billed. If ERL is a daily rate, how would day services, rec therapy, behavior or transportation be billed?
Under Medicaid, a provider cannot bill for two services at the exact same time. Medicaid does permit billing on hourly, monthly, etc. Billing a daily rate doesn't preclude other services from being on an individual's plan, but under the definition for ERL, the person must be present for at least a portion of that day in order to bill for that service.

Who do you anticipate using PAC rather than another form of residential support?
Families who may need a less comprehensive service support but need intermittent or targeted services would most likely utilize PAC. PAC would be accessed very similarly to the way it is currently accessed under the Family Supports Waiver, where families may choose to receive supports intermittently. This change was made in response to feedback from families who shared that after moving from the Family Supports Waiver to the CIH Waiver, they wanted to keep providers who provided PAC service as they transferred into the CIH waiver, because it worked for their family member.

With PAC now being proposed to be added to the CIH Waiver, is there a habilitation component requirement also being attached?
The service definition has not been changed from what is offered under the Family Supports Waiver.

What will be the waiting list time frame look like for someone who would want to use PAC under CIH?
Currently, PAC does not have a waiting list under FSW. DDRS does not anticipate a waiting list under the CIH waiver for this service.*

Under PAC, is part of that structure for individuals who are aging and no longer at the point where they are trying to set goals but really have a need for personal care services and maintenance?
It could be. As long as the individual could benefit from those supports and the provider is providing them within the context of that service definition.

Historically, the CIH waiver has been classified as a "habilitative" waiver in that services needed to have goals attached to them. I'm concerned that there's some confusion about the intent of the PAC service. On the FSW, PAC did not require formal goals on the ISP, but rather a "task list" of activities to be completed. It sounds like PAC for CIH will also not require goals in the ISP. How will PAC reflect a habilitative component?
The CIH is a 1915(c) waiver. A variety of services can be offered under an HCBS Waiver program. Programs can provide a combination of standard medical services and non-medical services. Standard services include but are not limited to: case management (i.e. supports and service coordination), homemaker, home health aide, personal care, adult day health services, habilitation (both day and residential), and respite care. States can also propose "other" types of services that may assist in diverting and/or transitioning individuals from institutional settings into their homes and community.

How do you see PAC as different from RHS?
The PAC service was devised to provide some intermittent support to participants as opposed to residential support options that are more cohesive throughout the course of a day, week, or month. PAC is more targeted and intended to provide interim level of support.

Do staff providing PAC have to have 20 hours of training?
This training requirement is not listed in the Service Definition for PAC.

If Behavior Management Services are not provided from someone outside the residential agency, who provides it? The Residential agency or DDRS?
Under Intensive Residential Supports - Behavioral, the definition is written with the intent that the service would be provided by someone within the agency that provides residential supports. This person may be an employee or a contractor with the agency. The intent is that behavioral providers be a part of the same provider agency to create a comprehensive, cohesive team.

Can a residential provider, provide behavior management?
Under Intensive Residential Supports, the definition states that behavioral supports are to be provided to support a person's needs. The definition is not written to allow a DSP to provide that support, but they may be provided by a Behavioral Supports clinician who may be an employee or a contracted agent of a residential provider agency.

Will Remote Support Technology be an allowable service under both the Medical and Behavioral Intensive Residential Supports (if appropriate for individual's needs)?
For individuals who need a wide spectrum of supports, a variety of Remote Support Technology items should be available under the waiver to give flexibility to teams in providing necessary supports.

Can the guardian be the Adult Family Living Caregiver?
Please review the Service Definition at http://www.in.gov/fssa/files/Adult_Family_Living.pdf on page 2 - Activities Not Allowed.

Will children currently served in SFC continue to be served by AFL? If not, what supports are available for these individuals?
There is currently only one individual under the age of 18 receiving Structured Family Caregiving services under the CIH Waiver, and that person will turn 18 prior to implementation and will not be affected by changes.

Will the monthly RN visit still be a component of Adult Family Living?
No, this component has been removed under the proposed changes.

Does Adult Family Living replace Structured Family Caregiving? Are guardians still being considered as providers?
Yes, Adult Family Living will replace Structured Family Caregiving. The service definition does allow guardians to provide the AFS service.*

Will respite be included as part of Adult Family Living?
Each provider agency will be required to have a contractual relationship with the person providing services in the home. The provider must give the person a certain amount of respite within that contract.

The issue that we have found when using a Behavioral Supports clinician that is employed by the residential agency is that the residential agency can force the hand of the clinician with regard to restrictions and such. Additionally, does it have to be a team decision to move an individual into the Intensive Residential Supports - Behavioral category? A concern of behavior agencies is that residential agencies will hire their own Behavioral Clinicians and then move the services. Essentially removing choice from individuals as to who provides their behavior management services.
Yes, the decision to move an individual to Intensive Supports must be the decision of the IST. DDRS has had conversations with Indiana ABC and understands that there are individuals who have the same behavioral clinicians for a long time and would like to keep their provider. Information related to these discussions can be included in Subcommittee meetings to help shape policy to incentivize strong relationship between individual's and their behavior clinicians.

There should be a requirement in place that if a long-term behavior clinician is in place and desired to be kept by the family/participant that the clinician be kept. Incentives alone will not require the IRS agency to keep the current behavior clinician. Additionally, there should be guidelines as to how they may establish a contract with the current behavior clinician, especially with regard to scope of role, autonomy in providing the service as a trained clinician, and rate of pay.
Thank you for your comment.

Is behavior management required to be provided by a residential provider or is this only in regards to individuals enrolled in residential services?
Behavior management will be provided by employees or contractors of residential provider agencies only for those individuals enrolled in Intensive Residential services.

Will a Behavioral Support provider who is not an ABA provider, but who has been the long standing Behavioral Support provider for a client still be allowed (should the individual/guardian so desire) to continue with that client if they are accepted into the intensive program?

If an individual desires to receive Intensive Residential Supports- Behavioral and is approved to do so, they will have to choose a provider that offers that service. As a part of that service, behavioral supports are to be delivered. The behavioral clinician can be an employee or contractor for the residential provider. The individual may not have to change the behavioral specialist if the residential provider chooses to contract with that particular clinician. DDRS has had conversations with Indiana ABC and understands that there are individuals who have the same behavioral clinicians for a long time and would like to keep their provider. Information related to these discussions can be included in Subcommittee meetings to help shape policy to incentivize strong relationship between individual's and their behavior clinicians.

Under Intensive Residential Supports – Behavioral, would a person need to change their behavior provider to the residential provider for the short amount of time they are receiving Intensive Supports, even if they would choose their original behavioral specialist?

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Are the Intense Residential Supports (IRS) Medical/Behavioral intended to be temporary services?

This service is generally intended to serve as a temporary or transitional service to prepare the waiver participant for living with a less intense level of paid supports. The person's ongoing need for that intensive level of service would be assessed by the Clinical Review Team.

Is Intensive Residential Supports – Medical intended to be short term or could it also be provided long term?

The way the definition was written is that intensive supports should not be provided forever; however, there are some individuals who would need to be in that service for a longer period of time. The Clinical Review Team and Individualized Support Team make final decisions on whom qualifies for the intensive services and how long they continue to need them.

Will there be any adjustment to the budget for individuals receiving Intensive Support services?

The intent is that, when a support team identifies an individual, the Clinical Review Team will look at the information provided and make a determination as to whether a person would benefit from Intensive Residential services. If the Clinical Review Team determines that the person is not eligible, this decision may be appealed. If they approve, the next step is for the Individualized Support Team to submit information regarding the individuals needed supports and potential budget to the Clinical Review Team for the level of supports that a person will need. Budgets are set in a way that allows the Individualized Support Team to identify the level of supports that an individual might needs, with the agreement and approval of the Clinical Review Team. Specific policies will be developed through collaboration with BDDS and the DDRS Advisory subcommittee.*

Can the Intensive Support Coordinator be an internal agency employee or an outside provider?
Any agency that applies and is approved to meet the criteria for Intense Support Coordination as outlined in the proposed amendment can enroll and accept clients.

Is Intensive Residential Support -Behavioral a replacement for the current ESN homes?
No, Intensive Residential Supports are a service under the CIH waiver, which is a home and community based waiver program. Extensive Support Needs homes are models are care delivered within an institutional setting which have different governing regulations.

What is the underlying rationale for providing the IRS-Behavioral?
DDRS seeks to ensure that individuals who have significant behavioral or medical needs have access to more comprehensive, individualized supports.

How will it work for someone to move from Enhanced Residential Living to Intensive Services? If there are limited numbers of intensive service providers statewide, this will require a participant to move from one environment to another in order to access services from the approved IRS provider and then back again once they aren't receiving IRL.
If an IST feels that a participant should be considered for intensive services, the IST will submit an application to the DDRS Clinical Review Team. The Clinical Review Team would then review the application to determine whether the participant meets the criteria to receive intensive services. As always, if a participant is determined to be ineligible for intensive services by the Clinical Review Team, that individual will have the right to appeal the decision. If determined eligible, the Clinical Review Team and the IST will work together to develop a plan of care that meets that individual's needs. It is not anticipated that individual's will need to move in order to receive this level of intensive support.

Would Intensive Residential Supports – Medical/ Behavioral be available only for someone living alone, or could a consumer who requires this service be in a setting with others who are not receiving this level of support?
Individuals receiving Intensive Residential Supports – Medical or Intensive Residential Supports – Behavioral are eligible to receive these services whether living alone or with others.

In the Intensive Supports category it seems this will greatly limit choice. Will there be providers available in all areas given the requirements. Will people have to move to where those services are provided?
DDRS does not anticipate that people will have to move to receive this service. DDRS has identified providers who have demonstrated abilities to provide this service and DDRS has also been contacted by providers who have expressed an interest in expanding their services that would be eligible to provide these services as well.
If there are specific regional concerns in terms of capacity, DDRS is open to hearing about those concerns, and that information would be helpful in determining provider qualifications under this service.

How will we transition individuals currently served in RHS who need to be served under the definition of Intensive Services?
Individuals and their teams will assess potential needs for services based on information already compiled, and then share that information with the Clinical Review Team. The intent is to allow for an individualized team discussion based on the person's needs.

What qualifies for Intensive Residential Supports?
Individualized Support Teams will need to apply to the state and the Clinical Review Team will review documentation submitted to determine whether an individual demonstrates a need for that service. If an individual is denied, he or she may appeal the decision.

Will the IRS provider be required to have the housing for those who need this service and need to be living alone?
Housing is not a cost that is covered under any HCBS Medicaid wavier program based upon CMS regulations. Housing is the responsibility of the individual themselves.

It is a major concern, based on previous experience, that if the behavior support is included within the residential agency that advocacy for that client will be reduced - as well as often the bottom line for residential agencies is financial and the risk becomes that the behaviorist will cater to the overall (and possibly unspoken) agency financial agenda.
DDRS will take this information into consideration. We intend to build in checks and balances to support all providers in providing services to waiver participants.

What about participants who are currently being provided level of supports consistent with Intensive Behavioral Supports? How will they be transitioned?
The determination as to whether an individual is eligible to receive Intensive Residential Supports – Behavioral or Medical will be based upon the recommendation of their IST and the needs of the individual. Each IST will need to submit an application for individuals they are supporting to ask that they be transitioned into this service.

What if the member does not want to move to a more intensive level of support? How will the clinical review team ensure that the member has choice and the care is person centered? Will the clinical review team work with the member to make sure this is their choice?
Individuals are members of the team, so DDRS should not receive applications for individuals who do not want to receive this service.

If an individual requires additional funding to meet need for intensive services but refuses to enter IRS, what choices will he be given?
These are some of the policy decisions that DDRS is currently working to make and that will be worked on with stakeholders in the DDRS Advisory subcommittees.

Clinical Review Team

What volume/capacity do you anticipate the clinical review team will be responsible for monthly/quarterly?
Volume and capacity will be dependent upon how many IST's decide that participants would benefit from this service. DDRS will have the ability to increase the number of clinicians available to provide this service if necessary.

Who will be on the DDRS clinical review teams? Will this be an independent entity or a state group?
The Clinical Review Team will be contracted to work with DDRS and will be selected through the standard procurement process.

Who is the DDRS clinical review team? Will members have choice in selecting the people who are overseeing their care?
DDRS will select the Clinical Review Team through the official procurement process and will provide that information to the public after procurement concludes. Regarding individual choice, the Clinical Review Team is not in place to oversee service delivery, but to serve as an agent of the state to provide consultation and guidance to the IST as needed. DDRS has not built in a system or way in which a participant would choose a clinician of the state who would be acting on its behalf.

Case Management

Case management may need to change. It would be difficult to negotiate if multiple case managers involved in a setting. Will there be one case manager per setting?
DDRS will not dictate the staffing of case managers in any given setting.

The ISP is extremely limited in what may be added into the system. Is DDRS going to change this so that case managers can actually enter everything required into the system? Right now it is not a good system to use and it would be nice if the system allowed us to do this.
DDRS agrees that the ISP does not contain all aspects that it should contain. As the waiver amendment process moves forward toward implementation, DDRS will begin to examine potential changes to the ISP.

Rates and Funding

Will Enhanced Residential Living still be a daily rate?
Yes. It will still be under a daily rate structure similar to how the daily rate is structured today.

Is ERL replacing RHS Daily Rate Services? If not, how will DDRS determine whether an individual is in RHS services or ERL services?
ERL will be a daily rate and available as a service option to participants currently on the daily rate. RHS hourly service will remain.*

Have rates been published for ERL and IRS?
Yes, rates have been published and can be found at:
http://www.in.gov/fssa/files/Rate_Determination_updated_20151125.pdf

Will daily rates be eliminate with the proposed changes?
Daily rates will not be eliminated under proposed changes.

Will rates change for Structured Family Caregiving?
Structured Family Caregiving will be replaced by Adult Family Living. Please review the proposed rates posted to the CIH Transform web page for more information.

Is it correct that "buckets" are going away for bman, days, etc.?
DDRS is looking to simplify resource allocation in order to best meet the needs of participants. What is being proposed is to provide each participant a total allocation of which they can choose the services they are eligible for without restricting those amounts into designated funding categories or “buckets”.

Will there be any "cap" on services with the new system (like the current 10 hour cap on CHIO for the RHS Daily provider)?
There are restrictions/limitations applicable within each service definition proposed in the amendment (such as the continuation of the 10 limitation on CHIO for ERL Services).

If ALGO is not tied to OBA, will 460 be changing too and when?
Yes, 460 will be changed. The process will follow the normal process for any rule revision, including public notice, public comment, and public hearings

Training

What training does DDRS plan to provide to providers in implementing these new services?
DDRS has begun the process of developing training, but has not determined dates, times, or topics for training. Following CMS approval of the waiver amendment, DDRS will begin sharing information about planned training activities.
DDRS has devised a process for how to manage policy development, implementation, and other items related to the CIH Transform so that stakeholder have ample opportunity to provide input. DDRS will share a copy of the communication materials that will be sent out to the DDRS Advisory Council. The DDRS Advisory Council will establish subcommittees to work on certain aspects of implementation under the waiver amendment. The DDRS Advisory Council is open to the public and meeting minutes will be published online. Some topics to be discussed are trainings, policy, and guidance documents.

When staffing emergencies and staff shortages occur, the proposed training requirements will further paralyze the system in meeting the needs of participants.
DDRS will review training requirements and clarify language to ensure that the intent to solidify existing training practices is made clear.

The proposed training requirements will be extremely problematic and expensive particularly in those situations where participants receive minimal services (former SILP participants). Meeting the requirement of 20 hours of shadowing could take up to a month to complete with a participant that only receives 4 hours a week. And typically these individual are able to participate to large degree in training their staff.
DDRS has received feedback that indicates that the training requirements included under CIH Transform have not given a clear indication of expectations for provider agencies. DDRS identified the included service definitions through collaboration with stakeholder groups, not with the intent of increasing the burden to providers, but with the intent of solidifying training requirements that are already in place across many provider agencies. DDRS will review this language and clarify the intent of these guidelines.